HOSPITAL/AMBULATORY SURGICAL CENTER GROUND RULES AND FEES

1. **GENERAL:** With regard to the DRG classifications listed below and for the hospitals in **Peer Group 1**, reimbursement for inpatient hospital services provided on or after October 1, 1999, and updated to remain current, is to be determined in accordance with the DRG classification and methodology that was developed by the Center for Medicare & Medicaid Services (CMS) for the Medicare program.

DRG No.	DRG DESCRIPTION
032	Concussion, age > 17 w/o cc
209	Major joint and limb reattachment procedures of lower extremity
210	Hip and femur procedures except major joint, age > 17 w cc
211	Hip and femur procedures except major joint, age > 17 w/o cc
217	Wound debridement and skin graft except hand, for musculoskeletal and connective tissue disorder
218	Lower extremity and humerus procedures except hip, foot, femur, age > 17 w cc
219	Lower extremity and humerus procedures except hip, foot, femur, age > 17 w/o cc
223	Major shoulder / elbow procedure, or other upper extremity procedure w cc
224	Shoulder, elbow or forearm procedure except major joint procedure, w/o cc
225	Foot procedures
227	Soft tissue procedures, w/o cc
236	Fractures of hip and pelvis
243	Medical back problems
254	Fracture, sprain, strain and dislocation of upper arm, lower leg except foot, age > 17 w/o cc
278	Cellulitis, age > 17 w/o cc
281	Trauma to the skin, subcutaneous tissue and breast, age > 17 w/o cc
415	Operating room procedure for infectious and parasitic diseases
440	Wound debridements for injuries
441	Hand procedures for injuries
445	Traumatic injury age > 17 w/o cc
487	Other multiple significant trauma
496	Combined anterior/posterior spinal fusion
497	Spinal fusion w cc
498	Spinal fusion w/o cc
499	Back and neck procedures except spinal fusion w cc
500	Back and neck procedures except spinal fusion w/o cc
507	Full thickness burn with skin graft or inhal inj w/o cc or sig trauma
511	Non-extensive burns w/o cc or significant trauma
520	Cervical spinal fusion w/o cc
537	Local excision and removal of internal fixation device except hip and femur w cc
538	Local excision and removal of internal fixation device except hip and femur w/o cc

For any hospitals or ambulatory surgical centers in **Peer Groups 2 and 3, and for all other DRG classifications not listed above**, reimbursement is to be at a variable discount rate. The variable discount rate for Peer Groups 1, 2, and 3 is 15.0%, 12.5%, and 10.0% respectively which is to be applied to the facility's usual and customary charge. **Ambulatory surgical centers are to be similarly grouped in association with the nearest proximate hospital, and are to be reimbursed in accordance with the variable discount rate.** Unless otherwise specified in this section of the fee schedule (Pathology and Laboratory charges, for example), outpatient services are also subject to the variable discount rate.

Limited data available for hospital Peer Groups 2 and 3, dictates that the DRG reimbursement system be introduced in phases beginning, with Peer Group 1. When sufficient data are available, the DRG reimbursement system may be expanded for use in the smaller hospitals.

HOSPITAL/AMBULATORY SURGICAL CENTER GROUND RULES AND FEES

PEER GROUP 1 (15.0% Discount)

Derby	Derby Ambulatory Surgery Center
Kansas City	Heart of America Surgery Center
Kansas City	Providence Medical Center-Providence Health
Kansas City	University of Kansas Hospital
Lawrence	Lawrence Memorial Hospital
Lawrence	Lawrence Surgery Center
Leawood	Discover Vision Surgery and Laser Center
Leawood	Skin and Mohs Surgery Center
Leawood	Surgery Center of Leawood
Leawood	The Headache and Pain Center
Leawood	Kansas City Otrhopaedic Institute
Leawood	Doctors Specialty Hospital LLC
Olathe	Olathe Surgical Associates
Olathe	Olathe Medical Center, Inc.
Overland Park	ADS Ambulatory Surgery Center
Overland Park	College Park Family Care Center, PA
Overland Park	Comprehensive Health Planned Parenthood
Overland Park	Endoscopic Imaging Center, LLC
Overland Park	Novamed Eye Surg. Center
Overland Park	Park Place Surgery Center, Inc.
Overland Park	South KC Surgical Center, LLC
Overland Park	Surgicenter of Johnson County
Overland Park	Heartland Surgical Specialty Hospital
Overland Park	Children's Mercy South
Overland Park	Menorah Medical Center
Overland Park	Mid-America Rehabilitation Hospital
Overland Park	Specialty Hospital of Mid-America
Overland Park	Saint Luke's South Hospital
Overland Park	Overland Park RMC
Overland Park	Select Specialty Hospital – Kansas City
Prairie Village	Physicians Surgery Center
Shawnee	KU Medwest Ambulatory Surgery
Shawnee	The Westglen Endoscopy Center
Shawnee Mission	Ambulatory Surgery Center of KC, Inc.
Shawnee Mission	Shawnee Mission Surgery Center
Shawnee Mission	Shawnee Mission Medical Center
Topeka	Cotton-O'Neil Clinic Endo. Ctr.
Topeka	Endoscopy and Surgery Center of Topeka
Topeka	Tallgrass Surgical Center
Topeka	Topeka Single Day Surgery
Topeka	Washburn Surgery Center, LLC
Topeka	St. Francis Health Center
Topeka	Select Specialty Hospital of Topeka
Topeka	Stormont-Vail Health Care
Topeka	Stormont-Vail West
Topeka	Kansas Rehabilitation Hospital
Wichita	Associated Eye Surgical Center
Wichita	Cypress Surgery Center
Wichita	Endoscopic Services, PA
Wichita	Galichia Heart Hospital, LLC
Wichita	Kansas Endoscopy, LLC
Wichita	Kansas Hearth Hospital
Wichita	Kansas Spine Hospital, LLC

HOSPITAL/AMBULATORY SURGICAL CENTER GROUND RULES AND FEES

PEER GROUP 1 (15.0% Discount) (continued)

Wichita	Mid West Surgery Center LLC
Wichita	Plastic Surgery Center
Wichita	Surgery Center of Kansas
Wichita	Surgicare of Wichita, Inc.
Wichita	Team Vision Surgery Center East
Wichita	Team Vision Surgery Center West
Wichita	The Center For Same Day Surgery
Wichita	Wichita Clinic Day Surgery
Wichita	Kansas Surgery and Recovery Center
Wichita	Select Specialty Hospital of Wichita
Wichita	Via Christi RMC
Wichita	Via Christi Rehab Ctr. - Our Lady of Lourdes Campus
Wichita	Via Christi Riverside Medical Center
Wichita	Wesley Medical Center
Wichita	Wichita Specialty Hospital
Wichita	Wesley Rehabilitation Hospital

PEER GROUP 2 (12.5% Discount)

Chanute	Neosho Memorial Hospital
Coffeyville	Coffeyville Regional Medical Center
Dodge City	Surgery Center of Dodge City, LLC
Dodge City	Western Plains Medical Complex
El Dorado	Susan B. Allen Memorial Hospital
Emporia	Emporia Ambulatory Surgery Center
Emporia	Newman Regional Health
Emporia	Emporia Surgical Hospital LLC
Fort Scott	Quinlan Eye Surgery and Laser Center
Fort Scott	Mercy Health Center
Garden City	Fry Eye Surgery Center
Garden City	Surgery Center of SW Kansas, LLC
Garden City	Saint Catherine Hospital
Great Bend	Central Kansas Medical Center
Great Bend	Surgical & Diagnostic Center of Great Bend
Hays	NW Kansas Surgery Center
Hays	Hays Medical Center
Hutchinson	Hutchinson Ambulatory Surgery
Hutchinson	Hutchinson Clinic, ASA
Hutchinson	Surgery Center of South Central Kansas
Hutchinson	Hutchinson Hospital
Junction City	Geary Community Hospital
Leavenworth	Cushing Memorial Hospital
Leavenworth	Saint John Hospital
Manhattan	Mercy Regional Health Center, Inc.
Manhattan	Manhattan Surgical Center, LLC
Newton	Newton Surgery Centre
Newton	Newton Medical Center
Newton	Prairie View, Inc.
Paola	Miami County Medical Center, Inc.
Parsons	Labette County Medical Center
Pittsburg	Century Surgical Associates, Inc.
Pittsburg	Mt. Carmel Regional Medical Center

PEER GROUP 2 (12.5% Discount) (continued)

Salina .....Laser Center
Salina .....Salina Regional Health Center
Salina .....Saint Francis at Salina
Salina .....Salina Surgical Hospital
Winchester .....Jefferson County Memorial Hospital, Inc. and Geriatric Center

PEER GROUP 3 (10.0% Discount)

All other hospitals are to be reimbursed at their usual and customary charge, less 10%. This is to include the following state institutions:

Rainbow Mental Health Facility at Kansas City, Kansas
Larned State Hospital at Larned, Kansas
Osawatomie State Hospital at Osawatomie, Kansas
Parsons State Hospital & Training Center at Parsons, Kansas
Kansas Neurological Institute at Topeka, Kansas

Out-of-state hospitals are subject to a 15% discount. Additionally, for any hospital that is paid using the variable discount method, regardless of peer group classification, and when the total charges for an inpatient hospitalization exceed $40,000, an additional 5.0% discount is to be applied to all the charges in excess of $40,000.

2. DETERMINING PAYMENT FOR INPATIENT HOSPITAL CLAIMS: Each and every claim for inpatient hospital services **(regardless of whether the hospital is located in Peer Group 1, 2, or 3 and may be subject to the variable discount rate)** is to be assigned a DRG classification. This is achieved by means of a DRG grouper. The grouper uses vital information from the claim, such as diagnosis and charge information, to determine which DRG classification best describes the inpatient stay. Only a CMS-DRG grouper (current with the care provided and employing the ICD-9 codes in effect at the time the services were provided) may be used to classify Workers Compensation claims for payment. Once a DRG is assigned to the claim, payment can be determined.

A hospital is to assign a DRG classification to the claim prior to submitting it for payment. The DRG is to be listed in form locator (field) 78 on the UB-92 claim form. Upon receipt of the claim, the reviewer/payer is to process the claim to verify the DRG classification assigned by the hospital. If the reviewer/payer processes a claim and arrives at a DRG classification other than the one assigned by the hospital, the reviewer/payer should contact the hospital to agree on the correct DRG classification that is necessary to process the claim.

After the claim has been assigned a DRG classification, payment is then determined in accordance with the methodology referenced below. Note that all inpatient claims will not be paid at the DRG rate. The only claims to be paid at the DRG rate will be those claims having been assigned a DRG classification that corresponds with those listed in this section of the fee schedule and for which the inpatient hospital services were provided by a hospital located in Peer Group 1. The Workers Compensation DRG payment system takes into account that within any given DRG classification there will be claims with actual total charges that are unusually high or unusually low. Payment for these unusual claims are not to be made at the DRG rate, but are to be paid according to the methodologies described later.

HOSPITAL/AMBULATORY SURGICAL CENTER GROUND RULES AND FEES

3. DRG CLASSIFICATIONS AND RATES (including low and high trimpoints):

DRG	DRG DESCRIPTION	TRIMPOINTS LOW	TRIMPOINTS HIGH	DRG RATE
032	Concussion, age > 17 w/o cc	3,138	34,287	12,551
209	Major joint and limb reattachment procedure of lower extremity	14,127	50,480	27,458
210	Hip and femur procedures except major joint, age > 17 w cc	7,731	71,027	30,924
211	Hip and femur procedures except major joint, age > 17 w/o cc	5,563	52,941	22,252
217	Wound debridement and skin graft except hand, for musculoskeletal and connective tissue disorder	7,665	95,232	30,659
218	Lower extremity and humerus procedure except hip, foot, femur, age > 17 w/cc	5,806	51,540	23,222
219	Lower extremity and humerus procedure except hip, foot, femur, age > 17 w/o cc	3,989	33,914	15,954
223	Major shoulder / elbow procedure, or other upper extremity procedure, w cc	5,359	61,011	21,438
224	Shoulder, elbow or forearm procedure except major joint procedure, w/o cc	4,554	23,644	11,984
225	Foot procedures	5,383	26,219	13,431
227	Soft tissue procedures w/o cc	4,106	41,225	16,423
236	Fractures of hip and pelvis	2,112	19,362	8,448
243	Medical back problems	1,651	17,598	6,602
254	Fracture, sprain, strain and dislocation of upper arm, lower leg, except foot age > 17 w/o cc	1,657	16,884	6,627
278	Cellulitis, age > 17 w/o cc	1,308	13,183	5,232
281	Trauma to the skin, subcutaneous tissue and breast, age > 17 w/o cc	2,275	23,667	9,099
415	Operating room procedure for infectious and parasitic diseases	4,826	57,294	19,305
440	Wound debridements for injuries	6,214	66,670	24,858
441	Hand procedures for injuries	4,894	60,937	19,575
445	Traumatic injury age > 17 w/o cc	2,485	32,474	9,940
487	Other multiple significant trauma	4,903	50,058	19,612
496	Combined anterior/posterior spinal fusion	29,125	108,113	58,326
497	Spinal fusion w/cc	12,824	78,573	38,844
498	Spinal fusion w/o cc	6,489	56,313	25,955
499	Back and neck procedure except spinal fusion w/cc	6,526	37,567	18,739
500	Back and neck procedure except spinal fusion w/o cc	6,359	24,701	13,200
507	Full thickness burn with skin graft or inhal inj w/o cc or sig trauma	4,660	53,011	18,640
511	Non-extensive burns w/o cc or significant trauma	3,778	51,485	15,114
520	Cervical spinal fusion w/o cc	13,617	33,052	19,834
537	Local excision and removal of internal fixation device except hip and femur w cc	8,261	90,297	33,046
538	Local excision and removal of internal fixation device except hip and femur w/o cc	3,469	24,583	13,874

4. DETERMINING PAYMENT: As reflected above, each of the specific DRGs has a designated DRG rate as well as a low trim point and a high trim point. Trim points have been set at statistically defined intervals and, as the name applies, serve to exclude outlier claims with actual total charges that are unusually low or high. The DRG payment rate is applied to those claims when the actual total charge falls between the low and the high trim points.

Example: DRG 500: Back & neck procedures except spinal fusion w/o cc

Low Trim: $6,359 High Trim: $24,701 DRG Rate: $13,200

Actual Total Charge = $23,000

Because the actual total charge is between the low trim amount and the high trim amount, payment will be made at the DRG rate of $13,200

Note: Any claim in DRG classification 500 whose actual total charge is not lower than $6,359 or higher than $24,701, such claim is to be paid at the DRG rate of $13,200.

A claim whose actual total charge is less than the low trim amount is considered a low-lier claim and one whose actual total charge exceeds the high trim amount is considered a high-lier claim. **Low-lier and high-lier claims are not paid at the DRG rate.**

5. **DETERMINING PAYMENT FOR A LOW-LIER CLAIM:** A low-lier claim is any claim when the actual total charge is less than the low trim amount for its assigned DRG classification. Such a type of claim is not to be paid at the DRG rate. Payment is determined by multiplying the actual total charge by .85 to achieve a 15.0% discount.

Example: DRG 500: Back & neck procedures except spinal fusion w/o cc

Low Trim: $6,359 High Trim: $24,701 DRG Rate: $13,200

Actual Total Charge = $6,000

Because the actual total charge is lower than the low trim amount, payment is determined by applying the low-lier calculation: $6,000 x .85 = $5,100.

Note: Payment for any claim in DRG classification 500 whose actual total charge is lower than $6,359 will be calculated according to this methodology.

6. **DETERMINING PAYMENT FOR A HIGH-LIER CLAIM:** A high-lier claim is any claim when the actual total charge is greater than the high trim point for its assigned DRG classification. Such a type of claim is not paid at the DRG rate. Payment is determined by multiplying the actual total charge by .85 to achieve a 15.0% discount. **Reimbursement for Pathology or Laboratory charges, and Surgical Implantables is defined as any other Non-DRG Hospital charges**.

Example: DRG 500: Back & neck procedures except spinal fusion w/o cc

Low Trim: $6,359 High Trim: $24,701 DRG Rate: $13,200

Actual Total Charge = $25,000

Because the actual total charge is greater than the high trim amount, payment is determined by applying the high-lier calculation: $25,000 x .85 = $21,250.

Note: Payment for any claim in DRG classification 500 whose actual total charge is higher than $24,701 will be calculated according to this methodology.

7. **DRGs AND PATIENT TRANSFER TO ANOTHER HOSPITAL:** When a hospital is unable to provide the level of care and service necessary for the management of a complex medical or surgical problem, transfer of the patient to another hospital facility may become necessary. In that event, charges incurred by the

transferring hospital are to be paid in accordance with that hospital's peer group assignment and the associated variable discount rate. The receiving hospital is to be paid in accordance with the entire DRG classification assignment for that admission.

8. **PRE-ADMISSION HOSPITAL CHARGES:** Any hospital charges incurred up to 72 hours prior to admission at the same hospital under the DRG payment system, are to be billed as part of that admission and not to be billed separately.

9. **PHYSICAL MEDICINE AND REHABILITATION:** Except for any inpatient hospital services that would be grouped within a DRG classification, reimbursement for any services provided by physical/occupational therapists is to be in accordance with the variable discount rate. However, for any hospitals having one or more affiliate clinics providing services on an outpatient basis, only one such clinic is allowed to submit billings using the hospital's Federal Tax ID number. The services for all other clinics affiliated with the same hospital are limited to the Maximum Allowable Fee for the respective *CPT* code that is contained within the Physical Medicine and Rehabilitation Section of this Fee Schedule.

10. **RADIOLOGY CHARGES:** Except for any inpatient hospital radiology services that would be grouped within a DRG classification for payment purposes, all other inpatient hospital radiology services are to be reimbursed according to the variable discount rate. Reimbursement for any outpatient radiology services provided by hospitals or ambulatory surgical centers are subject to the Maximum Allowable Fee for the respective *CPT* code that is contained within the Radiology Section of this Fee Schedule.

11. **PATHOLOGY OR LABORATORY CHARGES:** Except for any inpatient hospital services that would be grouped within a DRG classification for payment purposes, reimbursement for any other pathology and laboratory services provided by hospitals or ambulatory surgical centers are subject to the Maximum Allowable Fee for the respective *CPT* code that is contained within the Pathology and Laboratory Section of this Fee Schedule.

12. **INPATIENT CARE:** Charges for inpatient hospital care of more than one day shall be subject to review in cases where the patient is ambulatory. The attending health care provider will be required to submit sufficient information to substantiate why inpatient care was necessary. Once the patient's condition becomes such that further inpatient care is only a matter of personal convenience, the executive officer or administrator of the hospital or ambulatory surgical center should notify the employer (or insurance carrier) at once. Such notification should also be provided to the Director of Workers Compensation.

13. **DETERMINING PAYMENT FOR AMBULATORY SURGICAL CENTERS INVOLVING MULTIPLE OR BILATERAL PROCEDURES:** The Surgery Ground Rules for multiple or bilateral procedures are similarly applied to individual billed charges submitted by ambulatory surgical centers. Please refer to the **Surgery Section** of this fee schedule for details and examples. Note that the variable discount will still apply to any multiple or bilateral procedures.

14. **FACILITY FEES:** Ambulatory Surgical Centers must indicate that services provided and identified by a *CPT* code, reflect a facility fee, rather than the maximum amount related to the *CPT* code and its Unit Value defined for an individual provider.

    Outpatient facility fees are only reimbursed if the facility is credentialed at the appropriate level for the services provided. Such credentials include:

    A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
    B. Kansas Department of Health and Environment (KDHE) licensure as an ambulatory surgical center; or
    C. The facility level of safety, monitoring and quality of care as the JCAHO or KDHE licensure requires and has documented use showing the processes and procedures are in practice. In all other cases, a facility fee is not reimbursable without prior agreement from the payer, regardless of location of service.

HOSPITAL/AMBULATORY SURGICAL CENTER GROUND RULES AND FEES

15. **PHYSICIAN CHARGES:** A hospital or ambulatory surgical center shall bill for services provided by a physician **only if** that service involves: both professional and technical components; and, the physician is a contract employee of said facility. **Both** of these conditions **must** be satisfied for the hospital to bill. Services of this type would most frequently be in the physician specialty areas of radiology, pathology, or emergency room.

Billing for any physician service is to be submitted using the CMS 1500 form (or an equivalent form) containing the appropriate information as well as identifying the specific *CPT* code that was involved. Note also that the maximum allowable payment to a physician providing services in a hospital or ambulatory surgical center is to be **limited to the maximum allowable payment** that is contained within this Fee Schedule, which applies to the particular *CPT* code(s) being submitted.

16. **PROFESSIONAL AND TECHNICAL COMPONENTS:** Hospitals and ambulatory surgical centers must recognize that a difference may exist between the professional and technical components of services provided. It is, therefore, necessary to amend the billing process to specify, by use of modifiers, when only the professional component or the technical component was provided.

17. **ROOM:** Charges for other than semiprivate or ward service shall be subject to review, and must be accompanied by a statement identifying the source of authorization and necessity for other types of accommodations.

18. **SURGICAL IMPLANTABLES:** Reimbursement for any single surgical implantable item (e.g., rods, pins, screws, plates, prosthetic joint replacements) and which is made of plastic, metallic, or of autogenous/non-autogenous graft material that reflects a charge of $250.00 or more, is to be determined by cost to the hospital or ambulatory surgical center plus a 50% markup above the invoice cost. A copy of the invoice (date of purchase within twelve months of implantation) must be submitted with the bill.

This payment determination is not applicable when the total bill, including charges for surgical implantables, falls within the low and high trim points of any DRG specifically listed within this fee schedule.

19. **DURABLE MEDICAL EQUIPMENT:** Items such as wheelchairs, crutches, etc. when supplied by a hospital or ambulatory surgical center for the care of an inpatient or outpatient and billed with a charge of $250.00 or more will be reimbursed at invoice cost plus a 50% markup. Verification of such cost must be attached to the bill when it is submitted for payment.

In accordance with Kansas Law, the Kansas Department of Revenue does not collect sales tax on Durable Medical Equipment, if purchased with a prescription or written order from the physician ordering the item classified as Durable Medical Equipment.

20. **TRANSFUSIONS:** Charges for any blood transfusions shall be subject to review, to determine if the patient made any arrangements to obtain replacement units on his or her own.

21. **REVIEWS AND AUDITS:** The employer (or insurance carrier) has the right to conduct, or make arrangements for a bill audit of inpatient services to determine that such services were directly related to the compensable injury. The hospital or ambulatory surgical center should not make any additional charges on a given case under review during the course of the bill audit, unless it is for service which would not be covered under the Workers Compensation Act.

22. **COST CONTAINMENT:** Nothing in this section shall preclude an employer (or insurance carrier) from entering into payment agreements with hospitals or ambulatory surgical centers in their community to promote the continuity of care and the reduction of health care costs. Such payment agreements, if less, will supersede the limitation amounts specified herein. Please refer to K.S.A. 44-510i(e) for further clarification, if necessary.